

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

9 5 — 0 4 6

2. STATE:

LOUISIANA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

July 13, 1995

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

Secs. 1902(A)(28)(D)(i) and 1991(e)(7) of the Social Security Act

7. FEDERAL BUDGET IMPACT:

a. FFY 1994-95 \$ (149,555)

b. FFY 1995-96 \$ (599,509)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

~~Same (TN 93-17)~~

~~Same (TN 93-17)~~

* new

10. SUBJECT OF AMENDMENT: The purpose of this amendment is to require that nursing facility residents must be identified as needing specialized mental health services through the Pre-Admission Screening and Annual Resident Review process in order to receive services under the Mental Health Rehabilitation Program.

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ OTHER, AS SPECIFIED:

☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Rose V. Forrest

13. TYPED NAME:

for Rose V. Forrest

14. TITLE:

Secretary

15. DATE SUBMITTED:

September 27, 1995

16. RETURN TO:

Department of Health and Hospitals
Bureau of Health Services Financing
P.O. Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

October 11, 1995

18. DATE APPROVED:

10/11/95

PLAN APPROVED: ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

July 13, 1995

20. SIGNATURE OF REGIONAL OFFICIAL:

Steve McAdoo

21. TYPED NAME:

for Steve McAdoo
CALVIN G. CLINE

22. TITLE: Associate Regional Administrator
Division of Medicaid

23. REMARKS:

* pen and ink change at request of state letter dated 5/8/01

